



4. Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature with a II A/2A or above recommendation (examples: AHFS, Micromedex, NCCN)?	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Does the patient have medical record documentation showing ONE of the following: A) the comparable formulary alternatives (up to 3 formulary alternatives) are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy, B) the patient had an intolerance, inadequate treatment response, or allergy to the formulary alternatives (up to 3 formulary alternatives) in the same or similar class of drugs? [If yes, then documentation needs to be submitted for the initial request.] Clinical Rationale.	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Does the requested non-formulary drug have a generic equivalent available?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
7. Has the patient had an intolerance, inadequate treatment response, or allergy to the generic alternative, as documented in the patient's medical records? [If yes, then documentation needs to be submitted for the initial request.] Clinical Rationale.	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, then documentation needs to be submitted for the initial request.]	

I affirm that the information given on this form is true and accurate as of this date.

<b>Prescriber (Or Authorized) Signature and Date</b>